County of Grant Health Reimbursement Plan: County of Grant Coverage Period: 01/01/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Single/Limited/Family | Plan Type: HRA**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document, and access or request copies of the Uniform Glossary, at www.ebcflex.com or by calling 1-800-346-2126. This summary describes the coverage provided by the HRA; which is intended to operate in conjunction with your major medical plan. This summary only describes the coverage offered under the HRA.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	This Health Reimbursement Arrangement (HRA) plan may help you pay for some of the deductible expenses associated with your major medical plan. Check your major medical plan's Summary of Benefits and Coverage (SBC) for overall **deductible**.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services for this plan. Check your major medical plan's SBC for other **deductibles** for specific services.
Is there an out–of–pocket limit on my expenses?	No.	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services. Check your major medical plan's SBC for **out–of–pocket limits**.
What is not included in the out–of–pocket limit?	This plan does not have an **out–of–pocket limit**.	Not applicable because there is no **out–of–pocket limit** on your expenses under this plan.
Is there an overall annual limit on what the plan pays?	Yes, Yes, $1,500.00 for Single, $3,000.00 for Limited Family, $3,000.00 for Family	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You are responsible for all expenses above this limit. This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You are responsible for all expenses above this limit.
Does this plan use a network of providers?	Unknown.	Check your major medical plan's SBC to see whether there is a **network** of **providers**.
Do I need a referral to see a specialist?	No.	Check your major medical plan's SBC to see whether you need a referral to see a **specialist**.

Questions: Call 1-800-346-2126 or visit us at www.ebcflex.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.ebcflex.com or call 1-800-346-2126 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services Section below. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provid** **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- See your major medical plan's SBC to determine if your cost sharing depends on whether a provider is in network.

Common Medical Event	Limitations & Exceptions
If you visit a health care provider's office or clinic	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you have a test	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you need drugs to treat your illness or condition	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you have outpatient surgery	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you need immediate medical attention	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you have a	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs

Common Medical Event	Limitations & Exceptions
hospital stay	associated with Health Plan Deductible. Please see major medical plan's SBC.
If you have mental health, behavioral health, or substance abuse needs	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you are pregnant	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If you need help recovering or have other special health needs	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.
If your child needs dental or eye care	This EBC HRA is intended to operate in conjunction with your employer's major medical plan to assist with out-of-pocket costs associated with Health Plan Deductible. Please see major medical plan's SBC.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Any services not covered by the major medical plan.
- Services not first submitted to the major medical plan.

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- See major medical plan's SBC

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-346-2126. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Employee Benefits Corporation at 1-800-346-2126

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. NOTE: This HRA is intended to operate in connection with your major medical plan. Expenses not covered by this HRA may be covered under your major medical plan.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$
Co-pays	$
Co-insurance	$
Limits or exclusions	$
Total	**$**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.